Human Resources Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Certification Of Health Care Provider

Instructions:

1. Print or type clearly.
2. Complete items 1 through 3 (if you require leave to care for a family member, complete items 4 & 5). Your Health Care Provider must complete the remainder of this form.
3. Submit your completed certification to **Human Resources – Benefits, City of San José, 200 East Santa Clara Street, 4th Floor - Tower, San José, CA 95113**, Fax: (408) 999-0862, or Email: HRBenefits@sanjoseca.gov

Physician's Note:

DO NOT DISCLOSE THE UNDERLYING CONDITION

The **Genetic Information Nondiscrimination Act** (GINA) of 2008 prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Certification:

1. Employee Name:

2. Employee ID:

3. Department:

4. Patient Name (if different from employee):

5. Relation to Employee:

6. Page 3 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (None) ☐

7. a. State the approximate date the condition commenced, the probable duration of the condition:

Date condition commenced: __ / __ / __

Probable duration of condition or need for treatment: __ / __ / __ to __ / __ / __

b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment[i] described in Item 8 below)?

Yes ☐ No ☐

If yes, give the probable duration (of need for intermittent/part-time work): __ / __ / __ to __ / __ / __

8. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

b. If the patient will be absent from work or daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of an interval between such treatments, actual or estimated dates of treatment, if known, and the period required for recovery, if any:

9. a. If the medical leave is required for the employee’s absence from work because of the employee’s own condition, is the employee unable to perform work of any kind?

Yes ☐ No ☐

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee’s job (the employee should supply you with information about the essential job functions)?

Yes ☐ No ☐

If yes, please list the essential functions the employee is unable to perform:

10. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

Yes ☐ No ☐

b. If no, would the employee’s presence to provide psychological comfort be beneficial to the patient or assist in the patient’s recovery?

Yes ☐ No ☐

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

__ / __ / __ to __ / __ / __

Signature of Health Care Provider

Address **Telephone Number**

City, State, Zip **Date**

To be completed by the employee needing family leave to care for a family member:

In the space below, state the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than your current schedule:

Employee Signature **Date**

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Inpatient Care**
   Inpatient care *(i.e.,* an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Incapacity and Treatment**
   a) A period of incapacity[ii] of more than three **consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services *(e.g.,* physical therapist) under orders of, or on referral by, a health care provider; or

   (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**
   Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatments**
   A chronic serious health condition which:
   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
   (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (3) May cause episodic rather than a continuing period of incapacity *(e.g.,* asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision**
   A period of incapacity which is **permanent** or **long-term** due to a condition for which treatment may not be effective. The employee or family member must be under the **continuing supervision of, but need not be receiving active treatment** by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of absence to receive multiple **treatments** (including any period of recovery) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

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[i] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

[ii] "Incapacity" for purposes of FMLA is defined to mean inability to work, attend school, or perform other daily activities due to the serious health condition, treatment therefore, or recovery therefrom.